EPI-LOG

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Outbreak of *Vibrio parahæmolyticus* Infections Associated with Consumption of Raw Local Oysters

King County and other areas in Washington are experiencing a large outbreak of *Vibrio parahæmolyticus* infections associated with oyster consumption. Through July 27th, 27 confirmed cases have been reported in King County in 2006, 26 of these reported in July. From 1996 to 2005, 10.6 vibriosis cases, on average, were reported each year (range 4 to 27). Typically, a mean of 2 cases, are reported in July and 4.8 in August (range 1 to 14).

Exercising caution, some restaurants have voluntarily taken raw oysters off of their menus.

Vibriosis is the term used to describe illness caused by infection with *V. parahæmolyticus* and other *non cholera-causing Vibrio* species (including non-toxigenic *Vibrio cholera*). The illness is usually a moderately severe enteritis lasting 1-7 days and characterized by watery diarrhea, abdominal cramps, fever, nausea, vomiting, and headache. Up to 25 percent of cases may develop a dysentery-like syndrome with high fever, bloody or mucoid stools, and elevated WBC. The incubation period is typically 12-24 hours after exposure (range, 4-30 hours). Bacteremia is uncommon, occurring mostly in persons who are immune deficient. Wound infections can occur when broken skin is exposed to warm sea water.

Clinicians should consider *V. parahæmolyticus* in patients with a compatible clinical syndrome and take a travel and food history including history of eating raw or undercooked seafood, particularly shellfish. If possible, obtain details related to suspected shellfish consumption, including the location and dates of meals**. As with other enteric infections of public health significance (i.e., *E. coli* 0157:H7, shigella, salmonella) it is important that clinicians obtain stool cultures to confirm the etiology of infection. Culture results are important for public health investigations and resulting measures to interrupt transmission. Please specify on the microbiology lab request that *V. parahæmolyticus* culture is being requested so that the lab can use the proper selective culture media for vibrios (**Typically Thiosulfate Citrate Bile Sucrose Agar or TCBS agar**).**

V. parahæmolyticus lives worldwide in marine coastal environments. In warm weather, increasing numbers of the organisms multiply in the gut of filter feeding mollusks such as oysters, clams, and mussels. Oysters, commonly eaten raw, are the most common food associated with vibrio infection in the United States. ***V. parahæmolyticus* is killed by cooking to 145ºF.**

V. parahæmolyticus infection is not considered particularly communicable, though fecal-oral transmission is theoretically possible. **Persons especially susceptible to infection are those with chronic liver disease, decreased gastric acidity, diabetes, peptic ulcer, or immunosuppression.** Of the 25 cases reported so far in July 2006, approximately 1/3 reported taking prescription or over-the-counter antacids, H_2 blockers, or proton pump inhibitors.

The Washington Food Safety and Shellfish program monitors commercial and recreational shellfish harvest sites for *V. parahæmolyticus.* Sites where high levels are found are closed for shellfish harvesting. In addition, restaurants and other retail outlets are required to keep shellfish tags identifying the harvest site for every oyster, clam, and mussel they sell. When a confirmed or suspect case of vibriosis is reported, the case is rapidly interviewed by Public Health, and tags from implicated shellfish are retrieved used to identify implicated product and/or growing areas. Since July, multiple growing areas and beaches have been closed for shellfish harvesting in response to the increase in vibrio cases.

Cases of confirmed *V. parahæmolyticus* should be reported to Public Health during regular work hours at 206-296-4774 or on our 24 hour automated disease report line at 206-296-4782.

New Recommendations from the Advisory Committee on Immunization Practices

New Vaccine to Prevent Cervical Cancer & Genital Warts

In June 2006, the Advisory Committee on Immunization Practices (ACIP), recommended vaccination of girls and young women 9-26 years of age against human papilloma virus (HPV). The American Cancer Society estimates that 9,710 women in the US will be diagnosed with cervical cancer and 3,700 women will die of the disease in 2006. HPV is the sole cause of cervical cancer. The quadravalent vaccine, Gardasil® (Merck), is highly effective against HPV types 16 and 18, responsible for 70% of cervical cancers, as well as HPV types 6 and 11, which cause 90% of genital warts. Gardasil® was licensed by the Food and Drug Administration (FDA) on June 8th, 2006. According to the ACIP, three doses should be routinely given to girls when they are 11 or 12 years old. Vaccination can also be initiated in girls as young as nine years old at the discretion of the health care provider. The goal is to

vaccinate before onset of sexual activity at which time the incidence of HPV infection begins to rise rapidly. Women up to age 26 should be vaccinated because a significant proportion can still be protected against the cancer-causing HPV types though this age. The vaccine has no effect on established infections and is not a treatment for HPV infection. The vaccine is comprised of recombinant capsid protein from HPV that self-assembles into virus-like particles (VLPs) These particles contain no viral DNA and are therefore non-infectious. More importantly, these particles stimulate the production of antibodies that bind and neutralize the infectious virus. Gardasil® is not yet available through Washington State's universal childhood vaccination program because of the time lag between federal approval of a new vaccine and the allocation of funds to purchase the vaccine by the State legislature.

For more information about HPV and Gardasil®, see CDC's HPV web page at: www.cdc.gov/std/hpv/

Second Dose of Varicella Vaccine

ACIP also recommended a second dose of varicella (chickenpox) vaccine for children four to six years old to further improve protection against the disease. The first dose of varicella vaccine is recommended at 12 to 15 months old. Fifteen to 20 percent of children who have received one dose of the vaccine are not fully protected and may develop chickenpox after coming in contact with varicella zoster virus. Additionally, one dose of the vaccine may not continue to provide protection into adulthood when chickenpox is more severe. A second dose of varicella vaccine provides increased protection against varicella disease compared to one-dose. The ACIP also recommended that children, adolescents and adults who previously received one dose should receive a second dose. Until officially authorized by Washington's VFC program VFC vaccine should not be used for the newly recommended second dose of varicella.

Both of these recommendations are provisional, and will become official Centers for Disease Control and Prevention (CDC) policy when accepted by the director of CDC and published in CDC's Morbidity and Mortality Weekly Report (MMWR) – a process that takes an increasingly long time. Accordingly, the **ACIP posts their provisional recommendations on their web page at www.cdc.gov/nip/ACIP/default.**

HIV-AIDS Reported Cases for July, 2006

Total HIV/AIDS cases reported in this month's *Epi-Log* are lower than in the May 2006 issue. In March 2006, Washington transitioned from a name-to-code reporting system to a named HIV reporting system. Since then, HIV data have been accepted into the national HIV/AIDS database at the CDC. In the past, only AIDS data from Washington State were included in the regular national interstate deduplication exercises that ensure that people with HIV/AIDS in the U.S. are counted accurately. Now data about people with HIV or AIDS are included in these exercises. The June 2006 *Epi-Log* includes the results of an interstate deduplication exercise that for the first time included the records of people with HIV who were not know to have progressed to AIDS. This initial comparison and follow-up resulted in 121 Washington State cases (>66% in King County) determined to have been originally diagnosed, or having progressed from HIV to AIDS, in another state; consequently they were removed from the case count presented in this report.

Disease Reporting

AIDS/HIV.....(206) 296-4645
STDs.....(206) 731-3954
TB .....(206) 731-4579
All Other Notifiable Communicable Diseases (24 hours a day)..... .....(206) 296-4774
Automated reporting line for conditions not immediately notifiable.....(206) 296-4782

Hotlines

Communicable Disease.....(206) 296-4949
HIV/STD.....(206) 205-STDS

Public Health-Seattle & King County Online Resources

Home Page: www.metrokc.gov/health/
The *EPI-LOG*: www.metrokc.gov/health/providers
Communicable Disease listserv (PHSKC INFO-X) at: mailman.u.washington.edu/mailman/listinfo/phskc-info-x
West Nile Virus Updates and Current Testing Guidelines: www.metrokc.gov/health/westnile/advisories.htm

Reported Cases of Selected Diseases, Seattle & King County 2006

	Cases Reported in June		Cases Reported Through June	
	2006	2005	2006	2005
Campylobacteriosis	26	36	119	147
Cryptosporidiosis	6	7	15	47
Chlamydial infections	404	580	2,619	2,918
Enterohemorrhagic *E. coli* (non-O157)	1	0	1	4
***E. coli* O157: H7**	4	3	10	11
Giardiasis	7	17	56	60
Gonorrhea	170	169	997	830
***Haemophilus influenzae* (cases <6 years of age)**	1	1	1	2
Hepatitis A	1	1	6	7
Hepatitis B (acute)	3	2	9	13
Hepatitis B (chronic)	63	54	407	318
Hepatitis C (acute)	1	0	4	4
Hepatitis C (chronic, confirmed/probable)	116	107	737	662
Hepatitis C (chronic, possible)	21	36	157	215
Herpes, genital (primary)	71	157	408	409
HIV and AIDS (includes only AIDS cases not previously reported as HIV)	NA	27	86	220
Measles	0	0	0	0
Meningococcal Disease	1	1	5	11
Mumps	0	0	2	1
Pertussis	5	32	65	134
Rubella	0	0	0	1
Rubella, congenital	0	0	0	0
Salmonellosis	22	24	84	111
Shigellosis	3	4	18	30
Syphilis	14	4	117	70
Syphilis, congenital	0	0	0	0
Syphilis, late	4	7	36	41
Tuberculosis	29	20	57	56

The *Epi-Log* is available in alternate formats upon request.